State of Connecticut
Department of Public Health

Varicella Case Report Form

Please make and use copies of this form.

Report Status

Date reported: _____/_____/_____ Reported by: _____ Phone #: _____

Reporting Site/Clinic: _____ Town/City: _____

Site Type reporting:

☐ School ☐ Daycare ☐ Physician ☐ Health Dept. ☐ Other: _____

Demographic Information

Patient Name: _____ Date of Birth: _____/_____/_____ Age: _____
mm dd yyyy

Address: _____ City: _____ Zip Code: _____ Home Phone: _____

Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Alaskan/Native American ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Sex:** ☐ Male ☐ Female

Parent/Guardian Name (optional): _____ Parent/Guardian Work Phone (optional): _____

Case Attends: ☐ School ☐ Daycare ☐ Work ☐ College ☐ Other: _____

Name of Institution : _____ City: _____

Clinical Data

Rash Onset: _____/_____/_____
mm dd yyyy

Number of Lesions:

☐ Less than Average (<50) ☐ Average (50-250) ☐ Greater than Average (>250)

Hospitalized?: ☐ Yes ☐ No If yes, Hospital Name: _____ Days Hospitalized: _____

Diagnosed by:

☐ Parent/Guardian ☐ Physician/Nurse ☐ School ☐ Self ☐ Other: _____

Lab Confirmed: ☐ Yes ☐ No ☐ Unknown

Test type: ☐ DFA ☐ IgM ☐ IgG ☐ PCR ☐ Other: _____ Result: _____

Previous History:

Chickenpox?: ☐Yes ☐ No ☐ Unknown Age: _____

Vaccination?: ☐ Yes ☐ No ☐ Unknown

If yes, Date Administered: VZV Dose 1: _____/_____/_____ VZV Dose 2: _____/_____/_____

History of MMR:

Date Administered: MMR Dose 1: _____/_____/_____ MMR Dose 2: _____/_____/_____

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Revised August 2002